

Student Name _____

Student's
photo

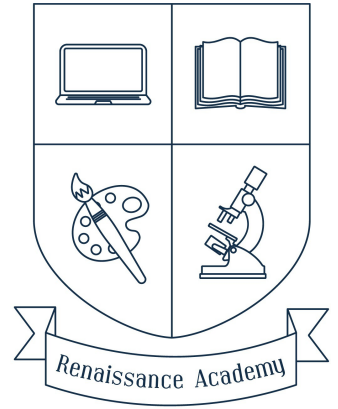
Renaissance Academy Medical/Mental Health Action Plan (MAP)

Date of Birth _____
Age _____ **Grade** _____ **School Year** _____

Page one of this MAP is to be completed, signed, and dated by a parent/guardian.
Page two of this MAP is to be completed, signed, and dated by the treating physician
or licensed prescriber.

Without signatures this MAP is not valid.

**The parent/guardian is responsible for supplying all medications, medication
release form, and any other needed equipment/supplies to Renaissance Academy
(RA).**



CONTACT INFORMATION

Call First

Try Second

Parent/
Guardian: Name: _____
Relationship: _____
Phone: Home: _____
Cell: _____
Work: _____

Name: _____
Relationship: _____
Home: _____
Cell: _____
Work: _____

Call Third (If a parent /guardian cannot be reached)

Name: _____ Relationship: _____
Address: _____ Phone: _____

MEDICAL HISTORY

Please describe the medical/mental health issue

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having medical/mental health concerns to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) I give permission for trained staff to help administer medication ordered and to contact the physician/licensed prescriber for clarification of orders, if needed.

Date _____ Parent/Guardian _____
Signature

Signs to watch for

Action



Signs of EMERGENCY

Action



Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan

Medication _____ **Route** _____ **Dose** _____

Other instructions/orders _____

Physician/Licensed Prescriber Name _____

Phone number _____ **FAX number** _____

Signature _____ **Date** _____